DEPRESSIVE SYMPTOMATOLOGY AND SPECIFICITY OF SOCIAL SUPPORT

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Summary.—Psychosocial interventions should be based on research which reflects the multidimensionality of psychosocial constructs. This study investigated six categories of social support which were associated with depressive symptomatology in a sample of 531 college students. The Social Provisions Scale was used to measure social support while the Center for Epidemiological Studies-Depression Scale was used to measure depressive symptomatology. Standard multiple regression analysis was used to analyze the variance contributed by each of the six categories of social support found on the Social Provisions Scale to depressive symptomatology. Specifically, the following categories of social support were significantly associated with depressive symptomatology: Reassurance of Worth (for male and female respondents) and Attachment (for females only). Implications for practice and research are discussed.

Psychosocial interventions should be based on research which reflects the multidimensionality of psychosocial constructs. Increasingly, programs are expected to be more specific in targeting their interventions and more precise in their measurement of effectiveness. With managed care and managed costs, health and mental health care settings are required to account for use of resources. Consequently, psychosocial researchers must examine dimensions of constructs more accurately (Fisher, 1993).

Recent research has indicated that social support is a multidimensional construct (Cutrona & Russell, 1987; Mallinckrodt, 1989). Cutrona and Russell's measure, The Social Provisions Scale (1987), includes six categories of social support, namely, "attachment (feelings of safety and security in a close emotional bond), social integration (interests and concerns are shared by others), reassurance of worth (having skills and abilities acknowledged), reliable alliance (assurance that one can count on assistance being available if needed), guidance (availability of confidants or authoritative others to provide advice), [and] opportunity for nurturance (the sense of being needed in vital

1Please address correspondence and reprint requests to Dr. Michele J. Hawkins, Department of Social Work, 777 Glades Road/Social Science 284, Boca Raton, FL 33431.
ways by other persons)" (Cutrona & Russell, 1987, pp. 41-42). Empirical research on various populations supports the multidimensionality of the social support construct. For example, Reassurance of Worth was the most important dimension of the Social Provision Scale for preventing burnout among older workers who had lost their jobs (Mallinckrodt & Fretz, 1988), among nurses (Constable & Russell, 1986), and among classroom teachers (Russell, Altmaier, & Van Veltzen, 1987).

Few studies, however, have examined the link between the various social provisions and depressive symptomatology as delineated by Cutrona and Russell (1987). In one such study (Cutrona, 1986), analysis for a sample of undergraduate students enrolled in an introductory psychology course examined the specific helping behaviors of respondents in relation to depressive symptomatology following stressful events. Behaviors related to Reassurance of Worth were important in preventing depressive symptomatology in the study. In another study of university students, Mallinckrodt (1989) found that scores on Reliable Alliance and Attachment were negatively associated with depressive symptomatology of clients of a university counseling center. Mallinckrodt also reported that scores on Opportunity for Nurturance were positively associated with depressive symptomatology. The author noted that this finding was difficult to explain but speculated that dependency of others may be overwhelming or that efforts to nurture others results in less attention to oneself and reduced the well-being of the individual providing nurturance. The present purpose, therefore, was to investigate the categories of social support or social provisions associated with depressive symptomatology among a sample of university students.

Method

Sample

From a list provided by the university Registrar and the Office of Student Affairs of 16,593 students attending a public university in the Pacific Northwest, the names of 1,200 students were randomly generated. Respondents were 531 or a 44.0% return rate.

The demographic distribution of the sample approximated that for the population of students at the university. Women represented 51.0% of the sample while men represented 49.0%. Most respondents were Euro-American (81.0%); the remainder were Asian/Pacific Islander (13.0%), African-American (1.5%), Latino/Mexican-American (1.5%), and other (1.9%). The percentage who did not indicate their ethnicity was 1.9%. Most respondents lived off campus (44.0%), 33.0% lived in residence halls, 11.0% lived with their parents, 8.0% in Greek housing, and 2.0% lived in cooperative housing.
Questionnaire

The mail questionnaire, prepared as specified by Dillman (1978), included two self-report inventories, the Center for Epidemiologic Studies-Depression Scale (CES-Depression) and the Social Provisions Scale (Cutrona & Russell, 1987).

Center for Epidemiologic Studies-Depression Scale.—The 20-item CES-Depression Scale examines the frequency of depressive symptomatology respondents have experienced during the past week. Individual items are scored from 0 to 3, with 0 indicating a symptom was experienced “rarely or none of the time” (less than 1 day), 1 indicating a symptom was experienced “some or a little of the time” (1 or 2 days), 2 indicating a symptom was experienced “occasionally or a moderate amount of time” (3 or 4 days), and 3 indicating the symptom was experienced “most or all of the time” (5 to 7 days). With samples of nonstudents, a high risk for depressive symptomatology is suggested by scores of 16 points or higher (Radloff, 1977; Wolinsky, 1988). Concurrent validity with the Beck Depression Inventory was reported by Beck, Ward, Mendelson, Mock, and Erbaugh (1961) and with the Zung Scale was reported by Zung (1965). This scale has been found to have high internal consistency (Radloff, 1977; Wolinsky, 1988) and test-retest reliability (Radloff, 1977). In studies involving collegiate samples, internal consistency was reported with Cronbach alpha of .88 and .89 (McDermott, 1987; McDermott, Hawkins, & Duncan, 1987; McDermott, Hawkins, Littlefield, & Murray, 1989). For the present sample α = .88. The similarity of the factor structures across groups is suggestive of its construct validity, i.e., Radloff (1977) and McDermott, et al. (1989) reported that the scale yielded four factors: Depressed Affect, Positive Affect, Somatic or Retarded Activity, and Interpersonal Relations.

Social Provisions Scale.—This scale (Cutrona & Russell, 1987; Russell, Cutrona, Rose, & Yurko, 1984) is a 24-item self-administered inventory that measures perceived social support. Items are scored on a 4-point summated scale with anchors of 1: strongly disagree, 2: disagree, 3: agree, and 4: strongly agree. The scale contains six social provisions or subscales: (1) Attachment, (2) Social Integration, (3) Reassurance of Worth, (4) Reliable Alliance, (5) Guidance, and (6) Opportunity for Nurturance. The factor structure has been reported through confirmatory factor analysis tests; the goodness of fit index for the subscales was .86 (Russell, et al., 1984). Test-retest reliability was reported as .59. Internal consistency range was measured with coefficients alpha of .76 to .84 when the scale was used for a sample of older adults and .61 to .78 for a sample of teachers. For the present sample α = .80.

When interpreting these findings, some limitations should be noted.
First, the items were self-reported, as most of the research of this type has been. Assessments of how people see themselves may not be as reliable as methods without self-interpretation. Secondly, there could have been respondent bias in terms of those returning the questionnaires, i.e., depressed persons may be less likely respondents. The sample may be biased with an over-representation of individuals who experience lower depressive symptomatology. Given confidentiality concerns of the Committee on Human Subjects, we could not survey nonrespondents.

RESULTS

Completed questionnaires were returned to the Office of Student Affairs. The raw data were entered on tape; the data were subjected to numerous edits and extensive validity checks to ensure the accuracy of the responses.

Frequency of Depressive Symptomatology

Forty-five percent of women and 38% of the men reported at-risk scores on the CES-Depression of 16 and above. In addition, more women reported having "moderate" and "severe" depressive symptomatology than men (see Table 1).

<table>
<thead>
<tr>
<th>Severity</th>
<th>Women (n = 271)</th>
<th>Men (n = 260)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few/No Symptoms</td>
<td>56</td>
<td>61</td>
</tr>
<tr>
<td>Mild (scores 16-20)</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Moderate (scores 21-30)</td>
<td>19</td>
<td>11</td>
</tr>
<tr>
<td>Severe (scores &gt;31)</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>

Confirmation of Factor Structure of the Social Provisions Scale

A confirmatory factor analysis was conducted on the intercorrelation matrix for the Social Provisions Scale (Cutrona & Russell, 1987) using LISREL 7. An acceptable fit was obtained $[\chi^2_{516}(N=516)=463.5, p<.001];$ adjusted goodness of fit index = .91; root mean square residual = .039. All of the items had sufficient loadings on their respective factors (> .30). Similar to the results reported by Cutrona and Russell (1987), high intercorrelations among the factors ranged from .63 to .93.

Univariate Correlations

Pearson product-moment correlations (Table 2) were computed between scores on the six social provisions and depressive symptomatology. All social provisions significantly correlated between .30 to .45 except Opportunity for Nurturance which correlated −.14 for the women and −.20 for the men.
Regression Analyses

A standard multiple regression analysis was performed with depressive symptomatology as the dependent variable and the six social provisions: Attachment, Social Integration, Reassurance of Worth, Reliable Alliance, Guidance, and Opportunity for Nurturance as the independent variables. Separate regression analyses were conducted for the women and men.

The regression analysis for the men indicated one dimension of social support to be significantly associated with depressive symptomatology, Social Attachment (B = -30, r = .39, p = .01) (Table 2). For the women, the regression analysis gave two dimensions of social provisions as significantly associated with depressive symptomatology, Reassurance of Worth (B = -2.01, r = -.44, p = .01) and Social Attachment (B = .73, r = -.37, p = .05).

Discussion

General Comments

The major finding was that lower scores on certain subscales were significantly associated with depressive symptomatology for both men and women. Specifically, reporting less reassurance of worth and less attachment were significantly associated for the women while scores on Reassurance of Worth was the only social provision correlated for men. This finding provides evidence to support the notion that certain social provisions may be more crucial for avoiding depressive symptomatology.

Few social provisions were significant in the regression analysis in contrast to the findings of the univariate correlations. As mentioned, all univariate correlations were statistically significant but of low magnitude, and scores on only one social provision, Opportunity of Nurturance, were weakly correlated (between .30 and .40) with depressive symptomatology. Although scores on all social provisions were significantly related to depressive symptomatology, only those on Reassurance of Worth and Attachment accounted for unique variances in depressive symptomatology. Therefore this study pro-
vides some evidence in support of the multidimensional nature of social support as a construct and in support of some provisions being more specifically associated with depressive symptomatology.

Implications

The findings can be interpreted that specificity in social support is clinically important in identifying which areas of social support the clinician might best target for intervention. Within this sample of college students, the women who reported higher depressive symptomatology might respond positively to interventions aimed at increasing their reassurance of worth and attachment. Men with depressive symptomatology may respond to the same interventions but present findings also suggest that clinical attention might be more direct toward attachment and less direct toward reassurance of worth. Were identifying such emphasis feasible, the specificity may allow clinicians to plan more effective models of care and programs that would yield clearer evaluations. Practice based on knowledge obtained from well-designed empirical studies allowing for the multidimensionality of psychosocial constructs is likely to be more fine-tuned and cost-effective and, thereby, a clinical asset in any health and mental health setting. In conclusion, this study indicates that social support is multidimensional. Further research is required with other samples to evaluate whether these findings hold.

REFERENCES


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